ST. MARY'S EYE & SURGERY CENTER

REGISTRATION FORM

540 Bergen Boulevard, Palisades Park, NJ 07650 | P: 201-461-3970 F: 201-242-9061
136-33 37 Avenue Suite 4C, Flushing, NY 11354 | P: 718-661-3800 F: 718-661-3812
370 Lexington Ave, Suite 1102, New York, NY 10017 | P: 888-792-2020

PATIENT INFORMATION

Last name:	First name:	Middle:	☐ Mr. ☐ Mrs. ☐ Ms.	Birth Date : / /	Age:	Sex: ☐ M ☐ F
Street address:		Social Security #:		Marital Status (circle one): Single / Married / Other		
City:	State:	ZIP Code:		Cell Phone #: ( ) –		
Preferred Language: ☐ English ☐ Spanish ☐ Korean	Email Address:			Home Phone #: ( ) –		
Primary Care Doctor (PCP):	**Pharmacy Name & Phone # :**					

EMERGENCY CONTACT

Name:	Relationship to patient:	Cell or Home phone #: ( ) –

INSURANCE INFORMATION

Name of primary insurance:	Subscriber's name:	Birth Date:	Policy #:
Does your insurance require a referral to see a specialist? ☐ Yes ☐ No			
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			
Name of secondary insurance (if applicable):	Subscriber's name:	Birth Date:	Policy #:
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize St. Mary's Eye & Surgery Center or insurance company to release any information required to process my claims.

X _____ / /

Patient Signature Date

PATIENT PRIVACY DIRECTIVE

In our efforts to comply with the Health Insurance Portability and Account Activity (HIPAA), we need to be certain that we guard your privacy according to your wishes. Please provide the names and phone numbers of assigned person(s) to whom we may discuss the following matters:

1. Leave messages regarding appointments, treatments, and/or test results.
2. Discuss your appointments and billing issues.

_____ _____

Patient/Authorized Individual (please print) Phone number

I ACKNOWLEDGE I HAVE SEEN A COPY OF THE "NOTICE OF PRIVACY PRACTICES" POSTED IN THE OFFICE LOBBY.

_____

Initials

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ST. MARY'S EYE & SURGERY CENTER

PRACTICE POLICY

TREATMENT CONSENT
I hereby authorize and consent to treatment at St. Mary's Eye & Surgery Center. This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis and treatment.

AUTHORIZATION & ASSIGNMENT
I authorize St. Mary's Eye & Surgery Center and/or my physician to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payments in full services, I assign to St. Mary's Eye & Surgery Center all payments for services rendered to my dependents or me.

MEDICARE CLAIMS
I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PAYMENT GUARANTEE

PATIENT RESPONSIBILITY - I understand that I am responsible for any amount not covered by insurance, with no exception. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by HMO, PPO, or a traditional group health plan. I understand that St. Mary's Eye & Surgery Center cannot bill my insurance company unless supplied with accurate and up-to-date insurance information and /or an original claim form. If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to, collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If my account is placed with a collection agency, I understand that St. Mary's Eye & Surgery Center may terminate availability of its services to me.

NON-PAYMENT AND ASSIGNMENT TO COLLECTION AGENCY - St. Mary's Eye & Surgery Center offers flexible payment arrangements and would like to help settle any balances that are my responsibility in a prompt manner. If I am experiencing difficulty in paying my bill, it is my responsibility to contact the billing office to resolve my issue. Overdue patient and insurance balances may be submitted for collections activity of non-payment. I am aware that any account assigned for collection activity cannot be "removed" from collections once it has been placed with the collection agency.

CONTRACTED INSURERS - If St. Mary's Eye & Surgery Center participates (is contracted) with my insurance plan, it will file claims as a courtesy to me. I will be responsible for: co-payments, coinsurances, annual deductibles, non-covered services.

NON-COVERED SERVICES - Insurers routinely state, "The determination of coverage is made at the time the claim is submitted." Providers often do not know if treatments will be covered until they receive the insurer's EOB(explanation of benefits). After the EOB for my submitted claim has been received at St. Mary's Eye & Surgery Center, I will be billed for any items not covered by my insurance plans. Services may be denied for coverage because the carrier considers the services: 1) medically unnecessary, 2) preexisting condition, or 3) cosmetic. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

TRANSFER OF CREDIT BALANCE - A credit balance resulting from payment to St. Mary's Eye & Surgery Center from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

PATHOLOGY AND LABORATORY CHARGES - Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. I will be responsible for any amount not covered by insurance.

FEES

CO-PAY REBILLING CHARGE - St. Mary's Eye & Surgery Center's contract with my insurer requires them to collect any co-payments in full at the time of service. If, for any reason, the correct co-pay is not collected at the time of service, a $10.00 service charge will apply for additional billing to collect co-pay.

RETURN CHECKS - A $35.00 processing fee will be charged for returned checks. Returned checks may also be forwarded to St. Mary's Eye & Surgery Center's collection agency for further action.

APPOINTMENT CANELLATION OR "NO SHOW" - As a courtesy, the office has an automated appointment reminder system that calls 2 days before and a day before to verify my appointment. This provides adequate time to cancel or change my appointment if needed. 24-hour notice is required to avoid the $25.00 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

MEDICATION REFILLS Patients are given enough medication to sustain them until their next visit. A follow-up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given.

NO INSURANCE CARD If I arrive without my insurance card for my first visit. I will be charged the standard commercial fee. St. Mary's Eye & Surgery Center is not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact. Refund of the full amount patient paid is done only after the insurance pays.

A copy of this authorization shall be valid as the original.

Print name of patient / legal representative

X _____ / / _____

Signature of patient / legal representative **Date**

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ST. MARY'S EYE & SURGERY CENTER

Medical History Questionnaire

Name : _____ **Date :** ____/____/____

1. Past Medical History

a. List all major illnesses :

_____

b. List any surgeries you had :

_____

2. Ocular History

a. List all major illnesses :

_____

b. List any surgeries you had :

_____

3. Medications

a. List the medications you currently take :

_____

_____

b. Do you have allergies including any medication? ☐ YES ☐ NO
If **YES**, please list them :

_____

4. Social History

a. Do you smoke? ☐ YES ☐ NO If **YES**, how much?_____/daily & since ___years ___months

b. Do you drink alcohol? ☐ YES ☐ NO If **YES**, how much? : _____

c. Please check ✓ one best answer to each question

Driving Status:
☐ Drives in the daytime
☐ Drives at night
☐ None

What is your caffeine use:
☐ Never
☐ A few times/month
☐ A few times/week

How often do you exercise:
☐ Never
☐ A few times/month
☐ A few times/week
☐ Once a day
☐ Other

d. Have you ever received Pneumonia vaccination? (Over 66 years old **ONLY**) ☐ YES ☐ NO

e. Occupation & Workplace:_____

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5. Review of Systems: Please check ✓ all that apply

Eyes
☐ Poor vision
☐ Eye pain
☐ Tearing
☐ Redness
☐ Other _____

General
☐ Fever
☐ Stroke
☐ Weight loss
☐ Weight gain
☐ Unusually tired
☐ Other _____

Ears, nose, throat
☐ Hard of hearing
☐ Stuffy nose
☐ Earache
☐ Cough
☐ Dry mouth
☐ Other _____

Cardiovascular
☐ High blood pressure
☐ Irregular pulse
☐ Other _____

Respiratory
☐ Congestion
☐ Wheezing
☐ Other _____

Gastrointestinal
☐ Upset stomach
☐ Diarrhea
☐ Constipation
☐ Hernia
☐ Ulcers
☐ Other _____

Genital, Kidney, Bladder
☐ Impotence
☐ Painful urination
☐ Frequent urination
☐ Yellow jaundice
☐ Other _____

Females
Pregnant?
☐ Yes ☐ No

Nursing?
☐Yes ☐ No

Muscles, Bones, Joints
☐ Joint pain
☐ Stiffness
☐ Swelling
☐ Cramps
☐ Arthritis
☐ Other _____

Skin
☐ Pimples
☐ Warts
☐ Growths
☐ Rash
☐ Other _____

Neurological
☐ Numbness
☐ Headache
☐ Migraine
☐ Seizures
☐ Paralysis
☐ Other _____

Psychiatric
☐ Anxiety
☐ Depression
☐ Insomnia

Endocrine
☐ Diabetes
(If **YES**, HbA1C: _____)
☐ Hyper/Hypo thyroid
☐ Other _____

Blood/Lymph
☐ Bleeding
☐ Cholesterolemia
☐ Anemia
☐ Blood transfusion

Allergic/Immunologic
☐ Sneezing
☐ Swelling
☐ Itching
☐ Lupus
☐ Rheumatism

6. Family History
Has any member of your family had these diseases? If **YES**, please check the following:

☐ Blindness
☐ Cataract
☐ Glaucoma
☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Stroke
☐ Cancer
☐ Thyroid Disease
☐ Arthritis